# Welcome

Date_____

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with your child. During the examination, we may be talking to your dental insurance to determine your orthodontic benefit.

Child's name _____
Last First Middle

Address _____
Street City Zip

Sex ____M ____F Age _____ Birthdate _____ Grade _____ School _____

Home Phone_____ Email _____

If patient is a minor, give parent's or guardian's name _____

Parents Marital Status ____Single ____Married ____Separated ____Divorced _____Widowed _____Partner

Child lives with _____Hobbies/Sports _____

Names and ages of other children in family _____

Dentist _____ Whom may we thank for referring you to our office? _____

## Responsible Party Information

Name _____
Last First Middle

Mailing Address _____
Street City Zip

Home phone_____ Work phone_____Email_____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____

## Primary Dental Insurance Information

(Parent who's birthday is first in the year)

Insured's Name_____ Insured's Social Security # _____

Relation to Patient _____ Birthday _____

Insurance Company_____ Group No._____ Subscriber No. _____

Orthodontic Benefit_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes, please fill out additional dental insurance info below:

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____Subscriber No. _____

Please complete both sides

## MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No to questions regarding your child (If Yes, please fill in details)

Yes No Is your child taking any medication? _____
Yes No Is he/she allergic to any medication? _____
Yes No Does he/she have any other allergies (latex, metal, seasonal, etc.)? _____
Yes No Any history of a major illness? _____
Yes No Has he/she had any major operations? _____
Yes No Has he/she ever been involved in a serious accident? _____
Yes No Has he/she ever taken a bisphosphonate medication (i.e. Fosamax, etc.) _____
Yes No Has a doctor ever instructed your child to take antibiotic premeds prior to dental treatment? _____

Circle any of the medical conditions below that your child has had or currently has.

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / AIDS | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

## DENTAL HISTORY

Dentist _____ Date of last visit _____

Why are you interested in orthodontic treatment for your child? _____

Yes No Has your child ever seen an orthodontist? If yes, who and when? _____
Yes No Is he/she presently in any dental pain? _____
Yes No Is any part of his/her mouth sensitive to temperature or pressure? _____
Yes No Has he/she ever experienced any unfavorable reaction to dentistry? _____
Yes No Has he/she ever lost or chipped any teeth? _____
Yes No Has there been any injury to the face, mouth or teeth? _____
Yes No Does your child's gums bleed when he/she brushes/flosses? _____
Yes No Does he/she have any type of thumb or tongue or nail biting or other habit(s)? _____
Yes No Is he/she a mouth breather? If yes, when awake or sleeping or both? _____
Yes No Have your child's tonsils or adenoids been removed? If yes, when _____
Yes No Does his/her teeth or jaws ever feel uncomfortable when awakened in the morning? _____
Yes No Are you aware of jaw clicking or popping in your child? _____
Yes No Are you aware of your child clenching his/her teeth during the day? _____
Yes No Are you aware of your child grinding his/her teeth? _____
Yes No Has your child complained of "tension" headaches? _____
Yes No Has your child ever experienced chronic ringing in your ears? _____
Other information about your child's dental health or previous treatment _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used to help determine appropriate healthful orthodontic treatment. If there are any changes in my child's medical status, I will inform the orthodontist.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance. In addition, I authorize Dr. Wahl to perform a complete orthodontic evaluation.

Signature: _____ Date: _____
(Parent of Guardian if patient is a minor)

Update: _____